GENERAL DISCUSSION *

J. LAWRENCE POOL, ELI S. GOLDENSOHN
H. HOUSTON MERRITT

Professor and Chairman, Department of Neurology
Dean, Columbia University College of Physicians and Surgeons

MODERATOR POOL: This ends the formal discussion, and I would like to throw the meeting open for general discussion. We have a few questions addressed to the panel, the first to Dr. Goldensohn: "*What about the matter of drug therapy after operation?*"

DR. GOLDENSOHN: We feel that lobectomy in patients with temporal lobe seizures is only part of their over-all care. Our study is not primarily oriented toward finding out whether lobectomy alone can achieve immediate and complete control of seizures. For this reason we continue to give the same drug treatment postoperatively as was given preoperatively, until enough time elapses to demonstrate that the seizures are controlled. At such time we reduce medication to easily tolerated therapeutic levels.

Perhaps I can answer some of the other questions now. Although we do have evidence that, in the human, continued discharging from a unilateral to a temporal focus can set up a new independent and sustained focus on the other side, we do not yet have good evidence to support the possibility that the process may cause irreversible changes. Our experience with the temporal lobe group, and also with patients who have had hemispherectomies, suggests that discharging from a secondary focus is reversible, even after many years.

The next question asks, "*How long do the good results of surgery persist?*" Our follow-ups are for three years or less, so that we cannot presume to state a longer period. But in Montreal, when Dr. Penfield's associates recently went over all their results, it was found that when there was complete seizure control during the first postoperative year, the results were maintained very well during the next ten years. It appeared that after the patient successfully climbed the ladder of the first year, he usually stayed on top. But control is sometimes obtained initially for a matter of months, without ultimate control of seizures.

DR. H. HOUSTON MERRITT: This is an important subject, and it has a

* Presented as part of a *Symposium on Temporal Lobe Epilepsy,* held at a combined meeting of the New York Neurological Society and the Section on Neurology and Psychiatry, The New York Academy of Medicine, November 9, 1961.

great many facets which cannot be considered in a short time. One point brought out tonight is that idiopathic epilepsy is a shrinking field. Not so very long ago it was stated that *petit mal* and psychomotor attacks were due to diffuse cerebral disturbances and were classic examples of idiopathic epilepsy.

Experience now shows that a high percentage of the patients with so-called psychomotor epilepsy have an organic lesion in the temporal lobe that is responsible for the discharging focus and the seizures. One aspect of the discharging lesion is quite interesting. One speaker brought out the point that it may be that it is not necessary that the discharging lesion be in the temporal lobe for the beneficial effects of temporal lobectomy to occur. Perhaps there is something specific about the temporal lobe so that, regardless of whether the lesion is in the lobe or whether a discharge from another point activates the temporal lobe, removal of the temporal lobe may prevent psychomotor seizures. The work of our neurosurgical colleagues should spur the neurologist to try to find a more effective medical treatment. If beneficial results follow surgical removal of the discharging focus, we should be able to discover some chemical that will inactivate the focus, so that seizures will not occur. This is not entirely hopeless. When an effective therapy was discovered for the common pathogenic bacteria, it was ineffective in tuberculosis and it was thought that it would be impossible to obtain an antibiotic that would cure tuberculosis. We now have medications that are effective in a high percentage of cases with *grand mal* types of seizure, and it is not impossible that we may find a chemical which will be effective in temporal lobe seizures, and which will not be unduly toxic.

Conclusion

MODERATOR POOL: I would like to say that, while it is clear that surgery is a last resort, it is true that follow-up studies, going on now for fifteen years in some of my own series, indicate that temporal lobe surgery can enable people to adjust to life, socially as well as economically, whereas they were unable to do so before operation. As previously brought out, most of these patients were not badly off psychiatrically, but were handicapped because of their temporal lobe seizures.

In conclusion, I think we all agree that surgery is definitely a last resort, and we all certainly hope that Dr. Merritt finds the right drug for the right thing, as he has done before.